STUDENT HEALTH SERVICES
DIVISION OF STUDENT AFFAIRS

1 University Drive
Pembroke, NC 28372-1510
TEL: 910.521.6219
FAX: 910.521.6549
shs@uncp.edu

2022-2023 ALLERGY INJECTION PARTICIPATION AGREEMENT

Instructions – Read carefully prior to completing Student Agreement. Students requesting allergy immunotherapy administration at the University of North Carolina at Pembroke Student Health Services (UNCP SHS) are required to complete this form. I request that UNCP SHS administer Allergy Immunotherapy as prescribed by my referring allergist. I also understand that UNCP SHS is not my primary care provider in respect to this therapy; any medical management related to this therapy, therapeutic monitoring of the therapy, and any necessary follow-up care are the responsibilities of my referring allergist; and if I have questions regarding the therapy or my medical condition related to the therapy, they should be directed to my referring allergist.

Deadline: This form must be completed and received in SHS prior to scheduling the first appointment. Consents and referral agreements will be updated annually.

I understand and agree to the following:

1. Allergy injections are given 8:30 am-11:30 am and 1:00 pm-4:00 pm M-F. Allergy injections may be administered by appointment or walk-in visits. **Hours may vary during school breaks and holidays. For updates, please visit https://www.uncp.edu/campus-life/student-health-services

2. A pre-therapy questionnaire will be completed at each visit prior to receiving any allergy injection. Any problems from previous injections, current illness, pregnancy, asthma exacerbations/symptoms or use of "Beta blocker" medications will be addressed.

3. You agree to abide by the injection schedule as prescribed by referring allergist.

4. You are required to have an *epinephrine auto-injector (e.g. EpiPen®)* in your possession at the time of allergy injection and it is recommended to be carried with you throughout the day. If an *epinephrine auto-injector* is not brought to the clinic appointment, rescheduling will be required; an SHS provider will be able to assist you with obtaining this prescription.

5. For your safety, students are required to wait in SHS for 30 minutes following each allergy injection. It is your responsibility to tell the nurse if unable to stay for 30 minutes PRIOR to receiving injections so the appointment can be rescheduled. ***Please report any reactions that may occur:***

    a. LOCAL: may consist of redness, itching and/or swelling at the area around the site of injection
    b. GENERALIZED or SYSTEMIC: **Report any distress IMMEDIATELY**. Any of these reactions require immediate evaluation and medical intervention. Symptoms may include but are not limited to: hives, swelling, tightness in chest, coughing, wheezing, excessive sneezing, itching of skin or palms, extreme redness in face and/or eyes, nausea, vomiting, dizziness or fainting.

6. Students are responsible for ordering and receiving allergy injection vials. SHS will inform you when new vials need to be ordered, but vials should be sent directly to you, NOT to SHS. SHS will store serums between 2°C and 8°C (36°F and 46°F) to reduce the rate of potency loss. However, SHS will not be held responsible for the integrity of the serum in the event of a power failure, storage equipment failure, or catastrophic event that may corrupt the integrity of the extract. Any unclaimed serum be discarded after May 31st.

7. Non-adherence with instructions given will result in the discontinuation of your allergy injection(s) at SHS.

Patient Signature_____**Date**_____

Patient Name & Banner ID (Printed) _____

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Information Needed for Allergy Injection Clinic

Patient Name: _____ Date of Birth:_____

To: Allergy Physician/Provider

Student Health Services looks forward to working with you and your patient. To help us better serve your patient we will need the following information before they can continue their allergy injections with us.

Please include the following information:

___1. Student's full name and date of birth on all information sent.

___2. Signed and dated copy of "Physician Order Sheet for Allergy Immunotherapy."

___3. Each allergy serum vial and/or paperwork should have the following information:

- Content of vial
- ICD-10 code
- Expiration date
- Strength

___5. Detailed protocols for dosing and dose adjustments including schedules for: escalation and maintenance dosing, the use of new vials, during seasonal exposures, if the constituents of the allergen immunotherapy extract have changed, missed doses, and adverse reactions or illness occur.

***Please note:** The referring allergy physician/provider is responsible for the management of the individual immunotherapy, allergy serum for injection and modification of dosing schedules. SHS will send updated treatment history to the referring physician/provider if outlined per protocol/order.

No allergy injection(s) will be given to students who take beta blockers, monoamine oxidase inhibitors (MAOI's), during pregnancy, those experiencing an asthma flare or similar illness, those with a febrile illness, systemic rash, sunburn or irritation at injection site, or those having a delayed reaction to serum.

Thank you for your time in gathering this information for us.

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2022-2023 Physician Order for Allergy Immunotherapy

Patient Name: _____ Date of Birth:_____

Please read the information below and sign your name at the bottom acknowledging the following:

1. As the allergy physician for_____,
   (Student Name-Please Print)
   I hereby authorize UNC Pembroke Student Health Services to administer allergy immunotherapy to the student according to the instructions and schedules submitted by me.

2. The initial allergy injection will be given at my office, not at UNC Pembroke Student Health Services. In order to maximize patient safety and decrease confusion, we require you to provide written, signed, and dated orders for the patient's initial orders as well as any dose adjustments that deviate from the standard adjustments included in your instructions. This may be accomplished through fax or instructions brought to us by your patient. We will follow our anaphylaxis protocol for treating reactions both local and generalized to ensure appropriate treatment during a potential emergency. If a systemic reaction occurs, after preliminary emergent care, the student will be transported by EMS to a local hospital. **If this patient has any systemic reactions to allergy injections at SHS, he/she will be referred back to your office for reevaluation and management.**

3. This patient has experienced any systemic reaction(s) to serum:
   Yes_____ No_____

   If yes, I will forward any information regarding the reaction.

4. This patient has an active prescription for an *epinephrine auto-injector (e.g EpiPen*®) (required to be in patient's possession at the time of allergy injection and it is recommended to be carried with them throughout the day).

   Yes_____ No_____

5. New allergy serum vials will be sent directly to the patient NOT to Student Health.

6. No expired serum will be administered.

Please review and complete this form with your signed and dated orders for this student, and have the student return the forms to Student Health Services or fax them to us at 910-521-6549.

By signing this form, I agree to work in conjunction with Student Health Services by following the guidelines outlined above to provide allergy injections to the above-named patient. I certify that this patient can safely receive injections outside of my office.

Physician name (printed): _____

Physician Signature: _____**Date:** _____

Address:_____

Phone: _____**Fax:** _____